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Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Note by the Secretariat

The Secretariat has the honour to transmit to the Human Rights Council the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, prepared pursuant to Council resolution 33/9. In the report, the Special Rapporteur addresses the relationship between the right to health and specific forms of deprivation of liberty and confinement in penal and medical regimes. Detention and confinement remain the policy tool preferred by States to promote public safety, "morals" and public health, doing more harm than good to public health and the realization of the right to physical and mental health. The Special Rapporteur calls for the full implementation of the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) and for the development of supportive community-based services as alternatives to detention and confinement in various cases.

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Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

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I. Introduction

1. In previous reports and country missions, the Special Rapporteur has attempted to shed light on how exclusion has negatively affected the right to health of those deprived of basic liberties and freedoms. In the present report, he uses a right-to-health framework to problematize the global approach to deprivation of liberty and confinement, pointing towards transformative directions for reform.

2. Given the breadth and scale of these issues, a comprehensive assessment is not possible within the space constraints of the present report. This is an initial contribution, focused on some practices where the right to health is a key element in meaningful assessment and guidance.

3. The report is a synthesis of insights acquired during country missions, literature reviews and multiple assessments of cases brought to the attention of the Special Rapporteur through the communications mechanism of the special procedures. The report was significantly informed and enriched through extensive consultations with a wide range of stakeholders, including people who have been deprived of their liberty, civil society representatives, members of the prison abolition movement, public-health experts, the World Health Organization (WHO) and academic experts. The Special Rapporteur is grateful for their generous commitment of time, energy and meaningful contributions.

4. Deprivation of liberty is a legally grounded term, and involves severe restriction of motion within a space that is narrower than that of other forms of interference with liberty of movement. It should be based on a judicial sentence, and is imposed without free consent. It is not prohibited per se, but such detention must be lawful and not arbitrary. Deprivation of liberty takes many forms, including police custody, remand detention, imprisonment after conviction, house arrest and administrative detention, as well as both involuntary hospitalization and institutional custody of children resulting from legal proceedings.[1]

5. Confinement is a term widely used in health and social welfare settings to indicate the restriction of an individual within a limited area, following medical or social-welfare advice. It may occur with or without the consent of the person and may include some generally accepted health-grounded practices, such as those applied in the context of the recovery period after a woman has given birth.[2]

6. While some forms of confinement, including retention in hospitals and in psychiatric and other medical facilities, may constitute de facto deprivation of liberty,[3] virtually all forms of confinement without informed consent represent a violation of the right to health.

7. Around the world, more than 10 million adults are imprisoned in penal settings.[4] These statistics fail to capture the global scale of persons restricted in other settings. For example, it is estimated that at least one million children are being held in other settings, that half a million adults are in compulsory drug detention and that thousands of women are being held in hospitals for non-payment of bills. An inestimable number of adults and children are confined in medical and social institutions, including persons with tuberculosis who are forcibly isolated for long durations, sometimes in prison-like settings. While the places of confinement differ, the shared experience of exclusion exposes a common narrative of deep disadvantage, discrimination, violence and hopelessness.

8. Restrictions on the liberty of movement have emerged in the past two centuries as the default tool of social control to promote public safety, "morals" and public health. This has included the detention, on the grounds of behaviour socially labelled as "immoral", of,

[1] See Human Rights Committee, general comment No. 35 (2014) on liberty and security of person, paras. 3, 5–6 and 10–14; see also E/CN.4/2005/6, para. 54.

[2] See Committee on the Elimination of Discrimination against Women, general recommendation No. 24 (1999) on women and health, paras. 2, 8, 22, 26 and 31.

[3] See A/HRC/30/37, para. 9.

[4] Roy Walmsley, World Prison Population List, 11th ed. (World Prison Brief and Institute for Criminal Policy Research).

among others, lesbian, gay, bisexual, transgender and intersex persons, rebellious young persons, drug users and women exercising their right to make choices concerning pregnancy prevention and termination. Confinement has become an institutional response to complex social problems, particularly affecting groups and communities left behind by public and socioeconomic policies. Some argue that prison systems and institutions are powerful instruments aimed at silencing the opposition or the "other", through either criminal sanctions or medical diagnosis and isolation.

9. The latter part of the twentieth century was marked by a rapid increase in rates of confinement within punitive legal and policy frameworks, including in relation to the drug trade, that laid the foundation for modern day, fast-track prison pipelines. Rapid deinstitutionalization in some countries, without corresponding investment in quality community-based services, occurred in parallel. People living in poverty and/or belonging to racial and ethnic minorities were caught in a widening punitive net with inadequate social, economic and legal protections.

10. The 2030 Agenda for Sustainable Development reflects the ambitious aspiration to end the vicious cycle of hopelessness, violence, exclusion and discrimination by addressing social inequalities and human rights so that no one, including persons confined or deprived of their liberty, is left behind.[5] There is strong evidence that any form of violence, including inside prisons and centres of confinement, poses a risk for the full realization of the right to health.[6] Many promising innovations are prioritizing investment in early childhood, healthy adolescence, competent parenting, good mental health and well-being, gender equality and the protection of women from violence, giving hope that the world can and will become less violent and that detention and confinement will decrease substantially.

11. For the first time, the field of mental health, supported by the Convention on the Rights of Persons with Disabilities other powerful political commitments,[7] is on the verge of freeing itself from a pattern of coercion and institutionalization in mental health settings.

12. Similarly, drug prohibition is increasingly acknowledged as a failed practice that has devastating consequences in terms of the right to health. A growing number of countries and municipalities are replacing punitive approaches to the use of drugs with modern policies based on public health and human rights principles, including decriminalization or legal regulation of drug markets and scaled-up investments in community-based social and health-care services, including harm reduction.[8] These promising trends give hope that the practice of mass incarceration of drug users may end.

13. New and stronger international political commitments to reduce incarceration where appropriate have been established.[9] A number of United Nations entities and human rights mechanisms have called for the immediate closure of all compulsory drug detention centres and/or movement towards the decriminalization of non-violent drug offences.[10] The global study on children deprived of liberty commissioned by the Secretary-General at the

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[5] For more on the 2030 Agenda in the context of the right to health, see A/71/304.

[6] See, for example, World Health Organization, *World Report on Violence and Health* (2002).

[7] See, for example, Human Rights Council resolution 36/13.

[8] United Nations Development Programme, *Reflections on Drug Policy and Its Impact on Human Development: Innovative Approaches* (2016).

[9] For example, the Doha Declaration on Integrating Crime Prevention and Criminal Justice into the Wider United Nations Agenda to Address Social and Economic Challenges and to Promote the Rule of Law at the National and International Levels, and Public Participation.

[10] See A/65/255; A/HRC/32/32; joint statement by United Nations entities on compulsory drug detention and rehabilitation centres, issued in March 2012, available from www.unodc.org/documents/southeastasiaandpacific//2012/03/drug-detention-centre/JC2310_Joint_Statement6March12FINAL_En.pdf; joint United Nations statement on ending discrimination in health-care settings, issued in July 2017, available from www.unaids.org/sites/default/files/media_asset/ending-discrimination-healthcare-settings_en.pdf; "Tackling the world drug problem: UN experts urge States to adopt human rights approach", press release, available from www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=19833&LangID=E.

invitation of the General Assembly holds much promise in terms of elevating the movement towards ending children's imprisonment.

14. On the other hand, there are many signs of increases in the use of confinement for minor offences and as the default response to problems relating to public safety, social order, immigration, political opposition or "morality". In some cases, punitive responses are applied disproportionately to address violence or radical extremism among young people. Growing numbers of women are being incarcerated, with a worrying number detained for choices regarding their reproductive health rights. The warehousing of refugees and migrants seeking safety and refuge remains a critical challenge.

15. Improving the conditions of the daily existence of the millions held in locked cells and wards and radically reducing the rates of such imprisonment remain of paramount importance. Equally important is the forging of efforts to fortify and transform communities to support reintegration, inclusive education, socioeconomic empowerment and well-being and, hence, the meaningful fulfilment of the right to the highest attainable standard of mental and physical health.

16. We are at a crucial point in terms of influencing how we conclude this decade and shape the next as regards ending the cultural dependence on confinement and incarceration.

II. The right to health in the context of confinement and deprivation of liberty

A. Intrinsic links, systemic omissions

17. Ensuring dignity by protecting the right to health has been an objective of prison reform legislation and advocacy since the earliest days of the modern prison. The current structures of confinement produce a vast geography of pain that transcends borders, resource settings and political systems. This is intimately linked to the right to health and well-being, not only of those deprived of liberty and confined, but also of communities, families, children and future generations. It is vital to consider the cyclical and transgenerational harm these systems produce.[11]

18. Securing the right to health is necessary for the enjoyment of a range of other rights. In contexts of confinement and deprivation of liberty, violations of the right to health interfere with fair trial guarantees, the prohibition of arbitrary detention and of torture and other forms of cruel, inhuman or degrading treatment, and the enjoyment of the right to life. Violations of the right to health emerge as both causes and consequences of confinement and deprivation of liberty.

19. The Special Rapporteur highlights five ways in which the links between the right to health and confinement and deprivation of liberty are evident:

(a) Failure to secure the right to health in early childhood through a comprehensive system of health care contributes to inequalities, poverty, discrimination and poor health in adulthood, feeding facilities of detention and confinement. The vast majority of people in closed settings come from marginalized and low-income communities;

(b) Punitive legal frameworks and public policies that make incarceration likelier hinder the realization of the right to health. Such frameworks and policies include laws criminalizing certain behaviours, identities or status (sex work, sexual orientation, gender identity, drug use, HIV status, non-adherence to tuberculosis treatment and exposure to infectious diseases) and health services needed only by women (i.e., abortion); the selective enforcement of loitering, vagabond and public disorder laws against those living in marginalized situations; and prohibitionist drug laws and policies that produce, inter alia, violent illicit drug markets and that lead to incarceration, driving people who use drugs away from community health care while providing little for health care inside prisons.

[11] Bruce Western and Becky Pettit, "Incarceration & social inequality", *Daedalus* (summer, 2010).

Broad and sweeping public-health frameworks established by law limit the toolbox available to policymakers for addressing health challenges, making detention and confinement the dominant and most restrictive means for addressing health concerns that are, according to evidence, better responded to in supportive community environments;

(c) The dominance of detention and confinement as a response to issues of public safety and public health has led to a monopolization of resources that should be redistributed to support the progressive development of robust health-care systems, safe and supportive schools, programmes to support healthy relationships, access to development opportunities and an environment free from violence;

(d) Safeguarding the right to health once a person is incarcerated is a challenging task. Prison itself becomes a determinant of poor health as a result of poor conditions of detention, the provision of health care under surveillance and/or a lack of access to health care, the enormous psychosocial pain and hopelessness linked to being deprived of liberty, and untreated pre-existing health conditions attributable to the conditions of living in poverty.[12] Mortality rates are high; in many cases, suicides and premature deaths in custody, almost all preventable, conclude harrowing tales of lives cut short;

(e) Detention and confinement among young, low-income families who have lost breadwinners and primary care providers to incarceration have a devastating impact on the social fabric of communities. Upon release, people commonly receive no health-care support when reintegrating into society. Furthermore, without robust health-care systems in the community, deinstitutionalization may lead to tragedy.[13] Criminal records, post-release surveillance and commitment orders follow individuals into their political, social and working lives, lowering resilience, creating barriers to opportunity and integration and ultimately undermining the right to health.

20. In sum, the enjoyment of the right to health in the context of confinement and deprivation of liberty is conspicuous by its absence.

B. Right-to-health framework

21. Human rights standards aimed at safeguarding persons deprived of liberty, or in confinement, against violations of their rights exist. However, the specificity of the normative scope and a lack of political will restrict the scope of responses to this highly complex social phenomena. A structural assessment, from a right-to-health perspective, of the "climate" of prison, detention and confinement, that is, how people experience life and survive once inside, how power is structured and organized and the structural factors that enable practices and institutions to persist, would help to broaden such responses.[14]

Obligations of the State

22. Under article 12 of the International Covenant on Economic, Social and Cultural Rights, States have the obligation to respect, protect and fulfil the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The Committee on Economic, Social and Cultural Rights has stated that, under the same article, States are obligated to refrain from denying or limiting equal access for all persons, including prisoners or detainees, to preventive, curative and palliative health services.[15] Other

[12] Dora M. Dumont and others, "Public health and the epidemic of incarceration", *Annual Review of Public Health*, vol. 33 (April 2012), and Ernest Drucker, *A Plague of Prisons: The Epidemiology of Mass Incarceration in America* (New York, New Press, 2013).

[13] See, for example, the joint urgent appeal, dated 28 November 2016 addressed to the Permanent Mission of South Africa to the United Nations Office and other international organizations in Geneva. Available from https://spcommreports.ohchr.org/TMResultsBase/DownLoadPublicCommunicationFile?gId=22868.

[14] Tomas Max Martin, Andrew M. Jefferson and Mahuya Bandyopadhyay, "Sensing prison climates: governance, survival and transition", *Focaal*, No. 68 (2014).

[15] See general comment No. 14 (2000) on the right to the highest attainable standard of health, para. 34.

international human rights treaties also contain provisions to protect the right to health of specific groups, including persons in situations of deprivation of liberty and confinement.

23. The Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) include provisions on the responsibility of States regarding health care for persons detained in prisons (rules 24–35). For example, States have the obligation to ensure that medical services in prisons guarantee continuity of treatment and care, including for HIV infection, tuberculosis and other infectious diseases, and drug dependence. Also set out in the Rules is the obligation to transfer prisoners requiring specialized treatment to specialized institutions or civil hospitals, and to ensure that clinical decisions are taken solely by responsible health-care professionals and not overruled or ignored by non-medical prison staff.

24. Bearing in mind the goal of the progressive realization of the right to health, measures are needed to ensure its realization in closed settings, including a plan to end forced confinement in hospitals and long-term care institutions. Such a plan must be supported by strategies to strengthen community-based alternatives.[16]

Informed consent[17]

25. The right to informed consent is a fundamental element of the right to physical and mental health. Informed consent involves a voluntary and sufficiently informed decision, and serves to promote a person's autonomy, self-determination, bodily integrity and well-being. It encompasses the right to consent to, refuse or choose an alternative medical treatment.[18]

26. While the right to consent to and refuse treatment involves careful consideration in the context of life-saving procedures, it must otherwise be respected, protected and fulfilled, notably in cases of isolation and confinement, where support and encouragement must be provided so that treatment is completed voluntarily. However, the right to consent to treatment continues to be ambiguously applied among those deprived of liberty, who remain at a high risk of being subjected to coercive, involuntary or mandatory testing and treatment, including compulsory drug testing, research trials and, among hunger strikers, force-feeding; in other cases, organs have been removed from executed prisoners without prior consent. These types of practices are harmful and some have implications on the reporting of symptoms for testing and treatment of stigmatized infections, such as HIV infection and tuberculosis.

Equality and non-discrimination

27. Entrenched inequalities and discrimination characterize the experience of deprivation of liberty and confinement, from the discriminatory apprehension of persons to the discriminatory and inequitable arrangement of services once a person is deprived of liberty or confined.

28. Health and prison officials often perpetuate discrimination through the denial of health care, including opioid substitution therapy, clean needles and syringes, antiretroviral therapy, and sexual health supplies or contraceptives. The status of being incarcerated can elicit prejudicial action by prison and health officials. Those seeking health care in prisons, detention centres and settings of confinement, particularly those with serious health issues, are often denied access as a form of informal punishment; access has also been denied where they are wrongly deemed to lack legal capacity on the basis of a perceived or actual impairment or other reasons. Barriers to ensuring non-discriminatory access to health care, including health-care facilities that are independently regulated outside the penal system, must be addressed immediately. The failures of staff training in this regard demonstrate the need for alternative and assertive approaches.

[16] A/HRC/35/21.

[17] For more on the issue of informed consent, see A/64/272, paras. 9, 28, 34 and 79–84.

[18] Ibid., para. 10.

International cooperation and assistance

29. International human rights treaties recognize the obligation of international cooperation, which includes cooperation regarding the right to health. International cooperation linked to the realization of a wide range of rights is also recognized in Sustainable Development Goal 17. Higher-income States have a particular responsibility to provide assistance in the area of the right to health, including as it relates to adequate access to health care in prisons and other settings of detention and confinement. International assistance should not support prison and health systems that are discriminatory or where violence, torture and other human rights violations occur. This is particularly so in the cases of drug detention centres, large psychiatric institutions and other long-term segregated care institutions.[19]

30. Through international cooperation, support for community-based health interventions should be scaled up to effectively safeguard individuals from discriminatory, arbitrary, excessive or inappropriate deprivation of liberty and confinement. It is worrying to see the continued imbalance between multilateral and bilateral assistance provided for the administration of justice and that provided for rights-based community investment. More work is needed to better understand the full scope of projects that continue to fund closed settings and impede community-based investment in health and social welfare.

Underlying determinants of health

31. Various factors affect the physical environment of persons who are deprived of liberty or confined. Adverse conditions can include poor sanitation and poor access to nutritional food, fresh air and potable drinking water. Some facilities were constructed on land contaminated with carcinogens.[20]

32. In these settings, including but not restricted to prisons, violence is common and takes many forms, including physical and sexual abuse by staff and peers, the use of physical and chemical restraints, forced medical treatment and solitary confinement. Furthermore, sexual violence against women has shown in multiple cases to be systematic and widespread. The most silent forms of adverse conditions of detention and confinement, including boredom and powerlessness, can often prove to be the most severe, notably affecting mental health while giving rise to feelings of hopelessness and despair and suicide attempts.

33. Overall, centres of detention or confinement are not therapeutic environments. In a previous report, the Special Rapporteur identified the underlying determinants of the right to mental health, including the creation and maintenance of non-violent, respectful and healthy relationships in families, communities and society at large.[21] In detention or confinement, where the person is surrounded by staff tasked with restricting freedom, it is difficult to establish these type of relationships, which hinder the full and effective realization of the right to mental health.[22] Even with noble efforts to establish a strong culture of respect and care, violence and humiliation usually prevails, adversely affecting the development of healthy relationships.

Health care

34. As elsewhere, for the right to health to be enjoyed in detention centres, health-care facilities, goods and services must be available, accessible, acceptable and of good quality.

35. Even with the most comprehensive health system in place, structural barriers may impede the full and effective realization of the right to health. Centres of detention and

[19] A/65/255, A/HRC/35/21.

[20] Judah Schept, "Sunk capital, sinking prisons, stinking landfills: landscape, ideology and the carceral state in Central Appalachia", in Michelle Brown and Eamonn Carrabine (eds.), *Routledge Handbook of Visual Criminology* (New York, Routledge, 2017).

[21] A/HRC/35/21.

[22] Peter Stastny, "Involuntary psychiatric interventions: a breach of the Hippocratic oath?" *Ethical Human Sciences and Services*, vol. 2, No. 1 (spring, 2000).

confinement often concentrate people from the most vulnerable situations, including those who are medically vulnerable. The centres are often characterized by inhumane physical and psychosocial environments and unequal structures of power frequently rooted within racist and violent pasts. The unpopularity and powerlessness of those deprived of liberty and confined leave them with no voice and few defenders to advocate for their dignity. These factors shape an ecology of deprivation that significantly compromises the ethical and effective organization and delivery of health care.

36. The availability of health-care services in detention and confinement centres is often compromised by managerial procurement decisions, particularly when those services are segregated from mainstream public-health infrastructure. Decisions to not make available certain health-care services are often taken by penal-oriented administrators instead of independent public-health actors, and security and punishment eclipse concerns for health. In many low-income settings, prison health systems lack the resources necessary to ensure the most basic provisions of health care.

37. In such settings, the accessibility of available health-care services is often dependent on negotiations with staff tasked with control and containment. Many people are denied access to appropriate medical services because of punitive or negligent actions of security staff. This has led to egregious violations of human rights, including preventable deaths.

38. In terms of acceptability, health-care services must: respect human rights and medical ethics; be culturally appropriate, sensitive to gender and life-cycle requirements and designed to respect confidentiality; and improve the health status of those concerned. Services in settings of confinement and deprivation of liberty must be culturally appropriate, as well as acceptable to adolescents, women, older persons, persons with disabilities, indigenous persons, minorities and lesbian, gay, bisexual, transgender and intersex persons.

39. As regards quality, evidence-based health-care protocols and practices must be used to support people who are deprived of liberty or confined, the majority of whom, because of their structural situation of disadvantage, will require significant provision of quality physical and mental health care. However, the delivery of such services faces systemic obstacles. The climate of deprivation and control adversely affects relationships, undermining the quality of health care. The absence of resources, particularly in low-income settings, further exacerbates this environment. The inappropriate use or overprescription of psychotropic medications, common in prisons as a means of behaviour control, and the use of solitary confinement, isolation and forced medical treatment are issues of quality of care and do not promote and protect the right to health. In higher-resource prison settings, cognitive-behavioural and other behaviour modification programmes raise serious questions of quality. Such programmes perpetuate individualistic approaches to offending as "abnormal", masking the political and social contexts that shape the lives and choices of those who have been detained or confined.

Participation

40. The effective realization of the right to health requires the participation of everyone, including those deprived of liberty or confined, or most at risk, in decision-making at the legal, policy and community levels, in particular in the area of health care. At the population level, enabling everyone to participate meaningfully in decisions about their right to health requires inclusive engagement, such as with those currently and formerly deprived of liberty and confined, their families, police, prison administrators, medical professionals, social workers, penal reformers and abolitionists and the wider community.

41. Health-care services in closed settings must empower users as rights holders to exercise autonomy and participate meaningfully and actively in all matters concerning them and to make their own choices about their health, with appropriate support where needed.

42. The inclusion of the voices of those directly affected must be encouraged, although this remains complicated owing to deeply unequal penal and medical power dynamics. Prisoner-led trade unions, voting rights movements and documentation projects, and movements of users and survivors of mental health systems, as well as the inclusive engagement of academia and the non-governmental sector, are powerful means for promoting meaningful participation.

Accountability

43. Accountability for the realization of the right to health requires three elements: monitoring; review, including by judicial, quasi-judicial and political or administrative bodies and social accountability mechanisms; and remedies and redress. Accountability is vital if the right to health inside prisons and other confinement settings is to be realized in practice.

44. Despite the commendable efforts of several monitoring mechanisms, human rights violations in prison and other centres of detention and confinement continue to be committed with impunity in a widespread and systematic manner. Individuals held in such centres often have limited or no access to independent accountability mechanisms, frequently because no monitoring body exists. Mechanisms charged with monitoring centres of deprivation of liberty rarely consider structural barriers, such as the disproportional detention of people in situations of vulnerability, including medical vulnerability, the existence of unequal power structures, often rooted in racist and violent pasts, and the little to no access to channels through which to voice demands, including health-care related demands.

45. The Special Rapporteur encourages national human rights institutions and national preventive mechanisms to give attention to those structural challenges. A right-to-health approach can be a useful tool in their monitoring and promotion functions. Persons formerly or currently deprived of liberty or confined, their families and civil society should be engaged in the development and implementation of accountability arrangements.

III. Relationship between mental health and forced confinement and deprivation of liberty

46. Actual and de facto deprivation of liberty has adverse effects on mental health, which may amount to violations of the right to health. Solitary confinement and protracted or indefinite detainment, including decades of detention in prisons or other closed settings, negatively influence mental health and well-being. The rates of poor mental health in prisons worldwide far exceed the rates in the general population. Being deprived of liberty itself is an emotionally fraught experience, carrying with it potential exposure to inhumane and crowded conditions, violence and abuse, separation from family and community, the loss of autonomy and control over daily living and an environment of fear and humiliation, and the absence of constructive, stimulating activities. Suicide rates in prisons are at least three times higher than those in the general community.[23]

47. While there has been a surge in research on mental health in prisons, it has been mostly limited to academic psychiatry and focused on disease prevalence and on improving services during confinement. There remains a dearth of research on how the constraints of a closed environment itself, particularly a punitive one, presents significant obstacles to the delivery of quality health care to those who are most in need.

48. Apart from recognizing that many people who are currently detained or confined should not be, there is an emerging consensus that prisons are not conducive to effective mental health treatment and that they are not the place for people identified as having a mental condition. This view, however, has led to forced confinement in mental health facilities, sometimes for indefinite periods, without meaningful safeguards to protect the right to health, to build on recovery or to guard against arbitrariness. For example, persons with intellectual and psychosocial disabilities who are in conflict with the law and who are deemed incapable of forming a rational judgment about their conduct ("insanity" defence) end up being held in custody in medical or security facilities instead.

49. The Convention on the Rights of Persons with Disabilities includes relevant provisions in this connection (arts. 12 and 14). The Committee on the Rights of Persons with Disabilities has established that the provisions represent an absolute prohibition on

[23] Seena Fazel and Jacques Baillargeon, "The health of prisoners", *The Lancet*, vol. 377 (2010).

involuntary confinement, including involuntary commitment of persons with intellectual and psychosocial disabilities to mental health facilities, strictly on the basis of actual or perceived impairment, as such confinement carries with it the denial of the person's legal capacity to decide about care, treatment, and admission to a hospital or institution.[24]

50. In accordance with the above-mentioned Convention, the recognition of legal capacity, including of persons with intellectual and psychosocial disabilities, applies to all aspects of life, including for the purposes of equal standing in courts and tribunals. In this regard, the Committee has recognized that if persons with disabilities, including intellectual and psychosocial disabilities, in conflict with law are deprived of liberty through a lawful and non-arbitrary process, they must be provided with reasonable accommodation that preserves their dignity, including in prison.[25]

51. The Special Rapporteur acknowledges these provisions. He echoes his previous call for a paradigm shift in the field of mental health, which abandons outdated measures resulting in the forced confinement of persons with intellectual and psychosocial disabilities in psychiatric institutions. He calls on States, international organizations and other stakeholders to undertake concerted efforts to radically reduce the use of institutionalization in mental health-care settings, with a view to eliminating such measures and institutions. He also calls on States to provide reasonable accommodation inside prisons for persons with all forms of disability lawfully and non-arbitrarily deprived of liberty, in a way that preserves their dignity.

52. Foundational to the way forward is the need for serious discussion about the role that perceptions of mental conditions play in propagating structures of confinement, underpinned by a false dichotomy that an individual coming into conflict with the law is either "mad" or "bad". People in conflict with the law, including those who may have a mental health condition, cannot be reduced to this binary categorization. The Special Rapporteur welcomes the growing debate around the subjective labelling of individuals and the inherent risks of diversion into coercive mental health settings. A fundamental part of this debate must include how the "insanity" defence and other criminal justice tools, such as mental health courts and security measures, may perpetuate systemic human rights failures in prisons and mental health settings. Many initiatives to provide mental health services in the community, without coercion or confinement, have shown promise. Empowerment is a basic precondition for the recovery of many persons who struggle with critical psychosocial challenges. Empowerment and recovery cannot happen in closed settings. Healthy, therapeutic relationships, based on mutual trust, should be fostered between users and providers of mental health-care services.

IV. Children deprived of liberty

53. The scale and magnitude of children's suffering in detention and confinement call for a global commitment to the abolition of child prisons and large care institutions alongside scaled-up investment in community-based services.

54. The Standard Minimum Rules for the Treatment of Prisoners, the first such rules adopted in the United Nations context, deliberately did not prescribe conditions and protection for child detainees, because they contained the principle that young persons should not be sentenced to imprisonment, which was repeated in the Nelson Mandela Rules. For over 30 years, United Nations rules in respect of juvenile justice have required that children be placed in institutions only as a measure of last resort and for the minimum duration possible.[26] States members of the United Nations long ago committed to depenalization and non-custodial measures for both children and adults.[27] Diverting

[24] Guidelines on the right to liberty and security of persons with disabilities.

[25] Ibid.

[26] United Nations Standard Minimum Rules for the Administration of Juvenile Justice ("the Beijing Rules"), rule 19.1; see also the United Nations Rules for the Protection of Juveniles Deprived of their Liberty ("the Havana Rules"), rule 1.

[27] United Nations Standard Minimum Rules for Non-custodial Measures ("the Tokyo Rules").

children from contact with the criminal justice system is now considered part of a strategy for ending violence against children within criminal justice settings.[28] The global study on children deprived of liberty commissioned by the Secretary-General is to include recommendations for the implementation of that strategy.[29]

55. Many of the damaging characteristics of prisons that we know to critically impede the enjoyment of the right to health by detained children, especially in terms of their psychological and emotional development, are also evident in large institutions nominally aimed at securing their welfare, including infant homes and education, health and welfare facilities for children with disabilities. Additionally, penal institutions are used to administratively detain children for political "offences", national security and immigration control. As such, all forms of detention severely compromise children's enjoyment of the rights to health, to healthy development and to maximum survival and development, in contravention of the International Covenant on Economic, Social and Cultural Rights (art. 12) and the Convention on the Rights of the Child (arts. 6 and 24).

A. Overview

56. There are no global statistics on the total number of children deprived of their liberty. Around one million children were estimated to be in detention in criminal justice systems at the turn of the millennium; in some countries, the majority were awaiting trial. Many were detained for non-criminal behaviour associated with poverty and discrimination, themselves breaches of children's rights. The independent expert for the United Nations study on violence against children found violence to be widespread in penal institutions.[30]

57. The likelihood of being detained as a child is linked to the social determinants of health.[31] Poverty, social exclusion, militarized school systems, gender, ethnicity and disability are all factors associated with the loss of liberty in childhood. Children from economically and socially disadvantaged communities, including those from ethnic minorities and indigenous populations, as well as those in care systems, are disproportionately deprived of liberty. Children with disabilities are more likely to be held in institutions, and to suffer appalling violence, often in the guise of "treatment".[32] Scaled up investment in tackling these underlying determinants of health is not only an obligation for the progressive realization of the right to health, but a promising strategy to prevent incarceration over the long term.

58. The Special Rapporteur has witnessed children with disabilities growing up entirely within the forced confines of large institutions, eventually moving into social welfare institutions for adults. While designed with good intentions, such paternalistic models are not compliant with various provisions protecting children's rights, including their right to healthy development. This sad legacy of confinement begins at the start of life in infant homes, characterized by emotional neglect that is itself a form of institutional violence. The Special Rapporteur reiterates previous calls to fully eliminate institutional care of children under 5 years of age and replace it with a comprehensive family support system.[33] This single measure, if taken seriously, could prevent millions from being deprived of their liberty.

59. While the Convention on the Rights of the Child does not exclude the detention of children, the strongest of presumptions against it are established (art. 37 (b)). Children may be detained only as a measure of last resort. This standard is not to be used retrospectively to justify existing structures. Instead, it is an obligation to exhaust all other strategies at the macro level and all other interventions at the micro level.

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[28] See the United Nations Model Strategies and Practical Measures on the Elimination of Violence against Children in the Field of Crime Prevention and Criminal Justice, paras. 30–31.

[29] General Assembly resolution 69/157.

[30] See A/61/299, paras. 61–62.

[31] A/HRC/7/11 and Corr.1.

[32] Paulo Sérgio Pinheiro, *World Report on Violence against Children* (2006), pp. 185 and 188.

[33] See, for example, A/70/213.

B. Penal institutions

60. Penal institutions were designed principally for adults. At best, separate facilities are provided for children, but they are still modelled on adult prisons. Prison is one of several forms of immigration detention used around the world. The fundamental right of the child to care and protection can never be realized within penal institutions.[34]

61. Children have been confined in cells, wards, corridors, exercise yards and visiting areas for weeks, months or even years. Childhood is a uniquely precious time in a young person's development; in penal settings, fresh air, windows and opportunities to play, exercise and explore outside are strictly limited, if available at all. A lack of nutritious and wholesome food saps children's energy; squalid conditions spread infection and disease. For children in immigration detention, release from captivity prior to deportation equals the loss of places they call home and the people linked to those places. Escorted transfers from an institution to an aircraft robs children of any final opportunity to say goodbye.

62. The impact of penal institutions stretches far beyond the curtailment of children's physical freedom; their mental well-being and potential for psychological and cognitive growth are all deeply and negatively affected. Research evidence shows that immigration detention aggravates pre-existing trauma in children. For some it is the worst experience of their lives.[35]

63. Adolescence is a critical period of cognitive and emotional development, affecting the whole of adulthood. The Special Rapporteur remains deeply concerned about how punitive responses to youth violence affect adolescent health and development.[36] Criminalization and incarceration have increased, despite the evidence that public-health approaches deliver better results.[37] In reality, children held in penal institutions, including for acts of violence, are those whose early childhood needs and rights have not been fulfilled. International human rights law requires children to be treated in accordance with their age and best interests.[38] Ensuring the full and harmonious development of children in society, from infancy to adolescence, is a core strategy for preventing youth crime.[39]

64. Since the entry into force of the Convention on the Rights of the Child, neuroscience research has revealed that the brains of adolescents are still developing in many critical ways. This calls into serious question the rationale for punitive, closed environments and methods of control.[40] Corporal punishment, humiliation, coercion and the denial of supportive environments that can ensure healthy, non-violent relationships and physical comfort can never elicit positive, long-term change in a child's behaviour.[41]

65. Many children are detained due to their mother's incarceration, when it is considered in the child's best interests to remain with his or her mother. The Special Rapporteur is of the view that this is too limited as an assessment of best interests. States must weigh the

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[34] See the Convention on the Rights of the Child, arts. 3 (2) and 40.

[35] International Detention Coalition, *Captured Childhood: Introducing a New Model to Ensure the Rights and Liberty of Refugee, Asylum Seeker and Irregular Migrant Children Affected by Immigration Detention* (2012), p. 49.

[36] The Committee on the Rights of the Child expressed similar concerns; see its general comment No. 13 (2011) on the right of the child to freedom from all forms of violence, para. 15 (c).

[37] Arianna Silvestri and others, *Young People, Knives and Guns: A Comprehensive Review, Analysis and Critique of Gun and Knife Crime Strategies* (London, Centre for Crime and Justice Studies, 2009), pp. 61–67.

[38] Convention on the Rights of the Child, arts. 3 and 37; Convention on the Rights of Persons with Disabilities, art. 7 (2).

[39] See United Nations Guidelines for the Prevention of Juvenile Delinquency (the Riyadh Guidelines), paras. 1–6.

[40] Barry Goldson and Ursula Kilkelly, "International human rights standards and child imprisonment: potentialities and limitations", *The International Journal of Children's Rights*, vol. 21, No. 2 (2013).

[41] WHO and International Society for Prevention of Child Abuse and Neglect, *Preventing Child Maltreatment: A Guide to Taking Action and Generating Evidence* (2006); Global Initiative to End All Corporal Punishment of Children, "Corporal punishment of children: review of research on its impact and associations", working paper (2016).

societal interests in punishing women with incarceration, for what are most often non-violent offences, with the best interests of the child and the obligation set out in article 37 (b) of the Convention on the Rights of the Child. That obligation requires the implementation of all means possible to avoid the detention of the child, including alternative models and responses for mothers.

66. The solitary confinement of children and the degrading and humiliating conditions in detention have been described as mental violence.[42] Many other daily forms of "organized hurt"[43] are perpetrated though no less pernicious means. Children's creativity, communication, sleeping, waking, playing, learning, resting, socializing and relationships are compulsively controlled in detention and transgressions punished, while those administering the punishment enjoy impunity.

67. Daily deprivations are often complemented by behavioural interventions in order to "treat" and "reform". Such "treatment" approaches further entrench the idea of a troubled child "in need of repair", ignoring that changes are needed to address right-to-health determinants, such as inequalities, poverty, violence and discrimination, especially among groups in vulnerable situations. This, in turn, leads to children living in forced confinement and fuels their struggles. Such oversimplified strategies are not in conformity with the right to health.

68. Coping mechanisms employed by stressed and desperate children, which include assaults against themselves and others, are perceived by society and judicial and welfare systems as acts that are self-harming, anti-social and/or violent. The harm inflicted by institutions themselves too often goes unacknowledged.

69. There can be no hesitation in concluding that the act of detaining children is a form of violence. The Convention on the Rights of the Child prohibits the use of detention as a default strategy. Looking forward, a child rights-based strategy must strengthen even further the presumption against detention of children with a view to abolition.

V. Women, the right to health, and confinement

70. Women comprise a small minority (7 per cent) of the global prison population, but the number of incarcerated women is increasing and at a greater rate than that of incarcerated men.[44] The number of women and young girls held outside of criminal justice settings worldwide is unknown. Most are first-time offenders suspected of, or charged with, minor, non-violent offences, pose no risk to the public and should probably not be in prison at all.[45] Paradoxically, the meteoric rise of women in detention regimes over the past two decades has brought greater visibility and gender-focused reforms, but with limited improvements as regards the suffering of detained women and the increase in their numbers.[46]

71. The suffering experienced by women who are imprisoned or involuntarily confined and the related negative impact on the enjoyment of their right to health is understood to be significantly greater than that experienced by men. Power and authority in prisons and other places of detention and confinement, such as large psychiatric institutions, emerge from historical patriarchal, hyper-masculinist constructions of punishment and control.[47] The acceptability of such environments for the realization of the right to health and for the well-being of women is thus questionable.

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[42] See Committee on the Rights of the Child, general comment No. 13, para. 21.

[43] Hans von Hentig, *Punishment: Its Origin, Purpose and Psychology* (1937); Barry Goldson, "Child imprisonment: a case for abolition", *Youth Justice*, vol. 5, No. 2 (August 2005).

[44] Roy Walmsley, World Female Imprisonment List, 4th ed. (2017).

[45] United Nations Office on Drugs and Crime (UNODC), *Handbook on Women in Prison*, 2nd ed. (United Nations publication, Sales No. E.14.IV.3).

[46] Cassandra Shaylor, "Neither kind nor gentle: the perils of 'gender responsive justice'", in Phil Scraton and Jude McCulloch, eds., *The Violence of Incarceration* (Routledge, 2008).

[47] M. Bandypadhyay, "Competing masculinities in a prison", *Men and Masculinities*, vol. 9, No. 2 (2006).

72. The manner in which women are actually or de facto deprived of liberty arises from structural inequalities and discrimination, harmful gender stereotypes and deep disadvantage, which lead to failure to secure their rights to social and underlying determinants of health, to reproductive autonomy, to an environment free from gender-based violence, and to services and support in the community. Once women are inside, the gendered and challenging environment of detention and confinement compounds their immediate and long-term health risks, reproduces past violence and trauma, and undermines the full and effective realization of the right to health for themselves and their dependent children and families left on the outside.

A. Addressing the gendered pathways of incarceration

73. Studies in several countries have found that violence, sexual, physical and emotional abuse and economic dependence are linked to women's incarceration. Many women in prison are mothers and the primary, if not only, caregivers for their children or other family members. In many countries, prison sentences for women lead to the incarceration of their infants or young children. Children left behind have limited contact with their mothers, often struggling to cope, living in street situations, in institutions, in foster care or with relatives.[48]

74. In some countries, pregnant women who use drugs, including legally prescribed drugs, face civil or criminal detention for extended periods of time, sometimes for the length of the pregnancy. This can have a discriminatory impact on women with disabilities who take prescription drugs while pregnant.[49] In other countries, women are imprisoned for "moral crimes", such as adultery or extramarital relationships, or to protect them from gender-based violence ("honour crimes").[50]

75. Criminal laws and legal provisions that restrict access to sexual and reproductive health goods, services and information also contribute to women's imprisonment.[51] In some States, dispensing information on preventing interrupting pregnancy or materials deemed to conflict with notions of "morality" or "decency" is criminalized with punishments ranging from fines to imprisonment. Criminal laws have also been used to prosecute women for other conduct, including failure to follow a doctor's orders during pregnancy, failing to refrain from sexual intercourse and concealing a birth.[52] Where abortion is illegal, women may face imprisonment for seeking an abortion and emergency services for pregnancy-related complications, including those due to miscarriages. Fear of criminal punishment for "aiding or abetting" abortions can lead health-care providers to report people suffering from pregnancy complications to authorities.[53]

76. A substantial proportion of women in prison are incarcerated for non-violent, low-level drug offences: between 40 and 80 per cent in some countries in the Americas, Europe and Asia.[54] While men are more likely than women to be involved in the drug trade, a

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[48] United Nations Development Programme, *Addressing the Development Dimensions of Drug Policy* (2015), p. 26; Moira O'Neil, Nathaniel Kendall-Taylor and Susan Nall Bales, "Communicating about women and criminal justice in the United Kingdom", FrameWorks Research Brief (June, 2015), p. 3; Carolyne Willow, *Children Behind Bars: Why the Abuse of Child Imprisonment Must End* (Policy Press, 2015).

[49] Amnesty International, *Criminalizing Pregnancy: Policing Pregnant Women Who Use Drugs in the USA* (2017).

[50] A/68/340.

[51] A/66/254, A/68/340 and A/HRC/14/20.

[52] See A/66/254, paras. 18, 38 and 62.

[53] See, for example, CEDAW/C/SLV/CO/8-9, paras. 37–38.

[54] See A/68/340, paras. 23–24; Rebecca Schleifer and Luciana Pol, "International guidelines on human rights and drug control: a tool for securing women's rights in drug control policy", *Health and Human Rights Journal*, vol. 19, No. 1 (2017); Thailand Institute of Justice, *Women Prisoners and the Implementation of the Bangkok Rules in Thailand* (2014).

significantly higher proportion of women than men are imprisoned for drug-related offences.[55]

77. In many countries, the proportion of women held in pretrial detention is equal to or larger than that of convicted female prisoners.[56] This heightens vulnerability to sexual abuse and other forms of coercion that can be used to extract confessions[57] and is compounded by race, disability, foreign national status and other situations of social discrimination.

78. Keeping women out of the criminal justice system in the first place by, for example, repealing laws criminalizing access to, and information about, sexual and reproductive health-care services, consensual adult sex, "morality" and minor drug offences is critical to protecting the right to health.

B. Conditions of incarceration

79. Once incarcerated, women often face discrimination based on sex and/or disability and are subjected to treatment and conditions that mirror the violence and abuse the majority have experienced prior to their detention. In a number of countries, because of the limited accommodation available for women prisoners, women are subjected to security levels not justified by the risk assessment undertaken on admission.[58] The lack of available medical or mental health services may also result in women being placed in more secure facilities than otherwise indicated.[59] The situation is exacerbated for women with disabilities because of the scarcity of facilities to accommodate them, and even more so for women with psychosocial or intellectual disabilities, whose actual or perceived impairment is often used as the basis for higher levels of security.[60]

80. Like their male counterparts, women in prisons recurrently face overcrowding, violence and unsanitary conditions detrimental to their mental and physical health and conducive to the spread of disease. It is frequently the case that little or no attention is paid to women-specific health-care needs, such as those related to menstruation, pregnancy and childbirth, menopause and sexual and reproductive health.[61] The lack of gender-specific health care in prison, including the lack of specialized obstetric and reproductive health services, poor treatment by staff, medical neglect and denial of medicines, lack of privacy for medical exams and confidentiality, and discrimination regarding access to harm reduction services, may amount to ill-treatment or in some cases torture,[62] and amounts to a violation of the right to health.

81. International standards require "special accommodation for all necessary prenatal and postnatal care and treatment" in women's prisons,[63] and that "adequate and timely food" and a healthy environment be provided free of charge for, among others, pregnant women and breastfeeding mothers.[64] However, prenatal care is inadequate or non-existent in many prisons, even where widely available in the general population, and nutrition substandard.[65]

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[55] Joanne Csete and others, "Public health and international drug policy", *The Lancet*, vol. 387 (April 2016); A/68/340, para. 26; CEDAW/C/BRA/CO/7 and Corr.1, para. 32; A/54/38/Rev.1, part two, para. 312.

[56] UNODC, *Handbook on Women and Imprisonment*.

[57] Open Society Justice Initiative, *Presumption of Guilt: The Global Overuse of Pretrial Detention* (New York, Open Society Foundations, 2014); UNODC, *Handbook on Women and Imprisonment*.

[58] UNODC, *Handbook on Women and Imprisonment*.

[59] See, for example, Anti-Discrimination Commission Queensland, *Women in Prison* (2006). Available from https://www.adcq.qld.gov.au/__data/assets/pdf_file/0018/5148/WIP_report.pdf.

[60] UNODC, *Handbook on Women and Imprisonment*.

[61] A/68/340. See also Human Rights Watch, *Going to the Toilet When You Want: Sanitation as a Human Right* (2017).

[62] See A/HRC/31/57, para. 26.

[63] The Nelson Mandela Rules, rule 28.

[64] United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules), rule 48.

[65] A/68/340.

Mistreatment of women during childbirth has been reported in prisons and immigration detention centres. Punishment by closed confinement and disciplinary segregation should not be applied to pregnant women, women with infants and breastfeeding mothers.[66]

C. Women with disabilities

82. Women with disabilities, especially psycho-social disabilities, are disproportionately represented in prisons, both as compared to the general population and vis-à-vis male prisoners.[67] The closure of psychiatric institutions and the lack of adequate housing, mental health and social services in communities have contributed to the increase in the population of women with psychosocial disabilities in prison.[68] The medicalization of women's behaviour and the construction of women in conflict with the law as "mad", "irrational" and "in need of repair" has contributed to the labelling of women in prison as having mental health conditions where men would not have been, and in turn, to the over-prescription of psychotropic medications for women suffering from normal levels of distress associated with detention.

83. Many prisons fail to provide reasonable accommodation to people with disabilities, which has significant consequences on their enjoyment of the right to health and, in some cases, may violate prohibitions against torture and ill-treatment.[69] The misclassification of women with mental disabilities as higher risk also impede their chances of early release, exacerbating existing mental health conditions.

84. The story of how women end up actually or de facto deprived of liberty, and the high levels of violence and suffering they experience once inside detention facilities, is closely linked to failures to respect, protect and fulfil their right to health. Gender-responsive reforms have failed to effectively address these challenges, which disproportionally affect women in vulnerable, disadvantaged and marginalized situations.

VI. From confinement to community: ending public-health detention

85. Confinement has long constituted a public-health strategy to stem the spread of infectious diseases and viruses, including leprosy, HIV and tuberculosis. Various legal frameworks, including national mental health laws, legitimize forced confinement on broad and subjective grounds, including medical necessity and dangerousness. Routinely, and in some cases increasingly, confinement is the policy instrument of choice for addressing complex social and public-health issues. Guided by worst-case scenarios, policies and practices regularly have a significant impact on groups in marginalized situations, entrapping them in criminal or public-health detention regimes on the basis of a health condition. This is despite mounting evidence that health outcomes for these groups, and for the communities in which they live, are better with health care and support in community settings. The place of public-health detention in our rapidly changing global world is a topical and important debate. In the light of the upcoming high-level meeting on the fight

[66] The Bangkok Rules, rule 22.

[67] United States of America, Department of Justice, "Disabilities among prison and jail inmates, 2011-12" (2015); Janet I. Warren and others, "Personality disorders and violence among female prison inmates", *Journal of the American Academy of Psychiatry and the Law*, vol. 30 (2002); Emma Plugge, Nicola Douglas and Ray Fitzpatrick, *The Health of Women in Prison: Study Findings* (University of Oxford, 2006).

[68] Jennifer M. Kilty, "'It's like they don't want you to get better': Psy control of women in the carceral context", *Feminism & Psychology*, vol. 22, No. 2 (April 2012).

[69] European Court of Human Rights, *Price v. the United Kingdom*, application No. 33394/96, judgment of 10 July 2001, and *D.G. v. Poland*, application No. 45705/07, judgment of 12 February 2013; United States Court of Appeals, Sixth Circuit, *Stoudemire v. Michigan Department of Corrections et al.*, case No. 14-1742, decision of 22 May 2015.

against tuberculosis, to be held pursuant to General Assembly resolution 71/159, in the present chapter the Special Rapporteur will focus on the illustrative case of tuberculosis.

86. Few populations experience more risk factors for tuberculosis than people deprived of liberty, owing to factors ranging from poor nutrition and unhygienic conditions to poor medical care. Prevalence rates in prisons are 3 to 1,000 times higher than those among the general population; prison populations account for 25 per cent of the tuberculosis burden in some countries.[70]

87. Rights violations contributing to the spread of tuberculosis result not only from the conditions of detention, but also from punitive responses to this and other infectious diseases, including criminalization, isolation, coercion and forced hospitalization. Too often, today's approaches to tuberculosis are as archaic as the disease itself and lack a modern, community-based approach to secure the right to health and better address the disease. Realization of the right to health requires a full commitment to developing responses to tuberculosis in the community, moving towards the full elimination of the use of punitive measures, including confinement, as a response.

A. Criminalization as a determinant of the right to health for people living with tuberculosis

88. Incarceration and detention approaches not only impede the realization of the rights to health, to informed consent, to privacy and to freedom from treatment, from inhuman and degrading treatment and of movement, but can also worsen social inequalities and lead to a paradoxical increase in tuberculosis incidence.[71]

89. In some countries, national laws permit mandatory hospitalization and forced treatment for persons with tuberculosis, in contravention of the right to informed consent, further creating fear and stigmatization of both the disease and people suffering from it. This drives people with tuberculosis symptoms away from the needed health care. Certain laws explicitly provide that examinations, hospitalization and observation may be carried out, isolation may be imposed and medical treatment may be provided without consent, in some cases without a court order. Some countries have tuberculosis-specific laws that include stigmatizing language, for example suggesting that people with the disease maliciously evade treatment, and authorize non-consensual hospitalization. Such legal frameworks reflect outdated approaches to health care, including approaches in which the amount of funding a health facility receives is determined by the number of occupied hospital beds.

90. People who are deprived of liberty disproportionately come from groups in disadvantaged situations who often have inadequate access to health-care services. Placing them in closed settings increases the risk that they will not have access to health care and can lead to the spread of tuberculosis where prison conditions, including overcrowding, poorly ventilated spaces, inadequate prevention, medical care and treatment, stress, malnutrition and denial of harm reduction services, elevate the risk of infection and transmission,[72] as does the high HIV rate in prisons.[73] People in detention often do not have adequate access to counselling and information about medicine and the side effects of treatment. Lack of access to quality diagnostic tools and medicines further contribute to

[70] See www.who.int/tb/areas-of-work/population-groups/prisons-facts/en/; F. Biadglegne, A. Rodloff and U. Sack, "Review of the prevalence and drug resistance of tuberculosis in prisons: a hidden epidemic", *Epidemiology & Infection*, vol. 143, No. 5 (April 2015).

[71] G. Mburu and others, "Detention of people lost to follow-up on TB treatment in Kenya: The need for human rights-based alternatives", *Health and Human Rights Journal*, vol. 18, No. 1 (2016), abstract.

[72] Masoud Dara, Dato Chorgoliani and Pierpaolo de Colombani, "TB prevention and control care in prisons". Available from https://pdfs.semanticscholar.org/c9d4/e241b8d4204108df36c16ad4e7cea4d8e56f.pdf.

[73] Stop TB Partnership, Key Populations Brief: Prisoners. Available from www.stoptb.org/assets/documents/resources/publications/acsm/KPBrief_Prisoners_ENG_WEB.pdf.

prisons as tuberculosis incubators, with as few as 18 per cent of prisons in high-burden tuberculosis countries having access to such tools.[74]

91. Excessive hospitalization, in some cases in prison-like hospital conditions for multidrug-resistant (MDR) and extensively-drug resistant (XDR) tuberculosis, is also an issue of concern. Many countries default to isolation, particularly in the context of such drug-resistant strains of tuberculosis. This results in fear and mistrust in public-health systems and inadequately supports the realization of the right to health of people with tuberculosis. Prolonged isolation, used for lengthy treatment of such drug-resistant tuberculosis, has also shown to induce feelings of fear, anger, self-blame, depression and suicide; there have been similar findings among incarcerated individuals.[75] This is unsurprising, as persons with the disease perceive prolonged isolation as imprisonment.

B. Community-based care and tuberculosis

92. WHO recognizes that community-based care can achieve results comparable to those of hospitalization and may result in decreased nosocomial spread of tuberculosis, and emphasizes that community-based care should always be considered before isolation.[76] Forced isolation is unethical and is not in conformity with the right to health.

93. Despite the evidence, and ethical and rights-based considerations, some criminal laws provide for confinement and punitive practices as part of national responses to tuberculosis. While these may be perceived as "public-health" measures to stem the spread of the disease, they entail significant human rights violations and further harm public health, undermining efforts to effectively address the disease. Rather than relying heavily on confinement, a rights-based approach calls for the development of well-resourced community health-care options, ensuring that persons with tuberculosis have adequate information, nutritional support and income and other support while undergoing treatment and/or if tuberculosis results in a loss of employment. While underresourced, small-scale, innovative, community-based treatment models have proven extremely effective, with high treatment completion and cure rates.[77]

94. Confinement as a response to tuberculosis increases stigmatization of people with the disease, driving those most at risk underground and away from health care. Confining people with tuberculosis not only puts them at risk by placing them in settings often characterized by inadequate access to treatment and support, but also fuels the spread of the disease within these settings. As a particularly stark example, incarceration has been utilized to isolate persons with tuberculosis, punishing them for not adhering to the treatment, even though violations of the right to health led to their non-adherence in the first place. Confinement inappropriately places the burden of tuberculosis treatment and care on the person, effectively isolating and criminalizing those who are sick instead of providing the health care and support needed to complete treatment. These practices must be brought to an end.

VII. Conclusions and recommendations

95. **Deprivation of liberty and confinement, when they are used as widespread forms of addressing various social, and often non-criminal, issues, create an environment that is detrimental to the enjoyment of the right to physical and mental**

[74] Banuru Muralidhara Prasad and others, "Status of tuberculosis services in Indian prisons", *International Journal of Infectious Diseases*, vol. 56 (2017).

[75] Kingsley Lezor Bieh, Ralf Weigel and Helen Smith, "Hospitalized care for MDR-TB in Port Harcourt, Nigeria: a qualitative study", *BMC Infectious Diseases* (2017).

[76] WHO, *Guidelines on Ethics of Tuberculosis Prevention, Care and Control* (2010), pp. 11–12.

[77] See, for example, WHO, Regional Office for Europe, *Good Practices in Strengthening Health Systems for the Prevention and Care of Tuberculosis and Drug-resistant Tuberculosis* (Copenhagen, 2016). Available from www.euro.who.int/__data/assets/pdf_file/0010/298198/Good-practices-strengthening-HS-prevention-care-TBC-and-drug-resistant-TBC.pdf.

health. While reality is such that certain cases of imprisonment may always be justified, it is unacceptable that in the twenty-first century detention and confinement continues to be regularly used for minor offences and for addressing public-health issues.

96. It is unacceptable that States continue to use detention and confinement as a preferred tool to promote public safety, "morals" and public health, doing more harm than good to social justice, public health and the realization of the right to physical and mental health.

97. Sustainable Development Goal 3 on ensuring healthy lives and promoting well-being for all at all ages will not be reached if the global community neglects to seriously address the use of detention and confinement as a public-health policy and to prioritize the development of effective alternatives. This retains its importance at all stages of life, starting in early childhood, moving through adolescence and youth and providing opportunities for healthy and dignified aging in community-based settings.

98. The Special Rapporteur urges States to:

(a) Fully abide by, and implement, the Nelson Mandela Rules, in particular as regards the provision of health care in prisons;

(b) Redistribute funds that currently support detention and confinement on the basis of public safety and public health towards enhancing public-health systems that include safe and supportive schools, programmes to support healthy relationships, access to development opportunities and an environment free from violence;

(c) Develop measures to address, on a non-discriminatory basis, the barriers faced by people in prison and other settings of detention and confinement in gaining access to health care, particularly women, children, drug users, persons with disabilities and persons with tuberculosis;

(d) Enhance community-based facilities that empower and promote recovery and healthy relationships, while radically reducing and progressively eliminating non-consensual measures and institutionalization in mental health-care settings;

(e) Effectively provide reasonable accommodation for imprisoned persons with disabilities, particularly those with psychosocial or intellectual disabilities;

(f) Implement national strategies towards depenalization and non-custodial measures for children in conflict with the law or who are already imprisoned;

(g) Fully eliminate institutional care of children under 5 years of age and replace it with a comprehensive family-support system;

(h) Scale up investment to deinstitutionalize children of all ages confined on health or social-welfare grounds in large institutions, such as infant homes and closed social care and mental health facilities, particularly children from vulnerable groups, including ethnic minorities and indigenous populations, and children with disabilities;

(i) Implement policies and specific measures to avoid by all means the detention of children, including the development of alternative models and responses for incarcerated mothers;

(j) Repeal laws criminalizing access to, and information about, sexual and reproductive health-care services, including with regard to the prevention and termination of pregnancy and consensual adult sex;

(k) Effectively provide special accommodation for prenatal and postnatal care and treatment in prisons and detention centres, jointly with adequate and timely food and a healthy environment, free of charge, for pregnant women and breastfeeding mothers, in accordance with the Bangkok Rules;

(l) End the criminalization, incarceration and confinement of persons with tuberculosis as a public-health measure, while developing community-based services that ensure access to adequate information, nutritional support and income;

(m) **Implement measures to empower detained and confined persons to exercise meaningful autonomy and participate in health-care decisions, with appropriate support and accommodation where needed;**

(n) **Promote the participation of formerly or currently detained or confined persons and their families and civil society in accountability arrangements, while developing strategies within national human rights institutions and national preventive mechanisms for the inclusion of a right-to-health approach in monitoring and promotion functions.**

99. **The Special Rapporteur calls on the international community to scale up support for community-based interventions that effectively safeguard individuals from discriminatory, arbitrary, excessive or inappropriate confinement.**

100. **The Special Rapporteur urges other relevant stakeholders to include in debates on mental health the issue of the "insanity" defence and of other criminal justice tools, such as mental health courts and security measures, considering how they may reinforce systemic human rights failures in prisons and mental health settings.**